

Child Health and Disability Prevention (CHDP) Program

MEDICAL RECORD REVIEW TOOL SCORING INSTRUCTIONS AND REVIEWER GUIDELINES

General Guidelines for Review of a Medical Record

- All records, including electronic records, must contain the following elements: client's first and last name, birth date, unique client numbers established for use at the clinical site, current address, home/work phone numbers, name of parent(s) if client is a minor, emergency contact person and phone number, and the designated primary care provider.
- All sites including mobile vans, satellite centers and school-based clinics must be reviewed using the Medical Record Review Tool (DHS 4492) in conjunction with the CHDP Facility Review Tool (DHS 4493) during an on-site visit to a Provider.
- Local CHDP Programs enrolling a **new** provider should request a sample(s) pediatric chart(s) with equivalent services.
- On subsequent reviews, request current CHDP records.
- This form may be used for more than one provider. List each provider's name and initials on page 3, and write the provider's initials under the appropriate medical record number.

Directions for Scoring

A total of eight items are scored for every record reviewed. Every item is weighted.

11 items weighted 1 = possible points = 11

38 items weighted 2 = possible points = 76

Total possible points = 87 (per record reviewed)

- Review a minimum of **five** randomly selected medical records.
- Score full weighted points (1 or 2 as designated) for each criterion that is met. Do not score partial points for any criterion.
- Score zero points if criterion is not met.
- Not applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed. Score N/A with the full weighted points (1 or 2 as designated) for that criterion.
- Add the category scores for each record reviewed to determine the total points of the review score.
- Multiply the number of records reviewed by the total possible points per record to score the total possible points (85 x number of records reviewed.)
- Calculate the percent score by dividing the Review score points by the total possible points. For example,

	Review Score Points Awarded	Total Score Points Possible	Percent Score Calculation
One Record	75	87	75 divided by 87 x 100 = 86%
Five Records	282	435	282 divided by 435 x 100 = 65%

- Round percentages to the next smaller percentage for .1–.5, or to the next larger percentage for .6–.9. For example, the above percentage for five records was 64.8%, would be reported as 65%.
- Determine the degree of successful completion by the Business Entity for the Medical Record Review using the following thresholds:
 FULL APPROVAL = 85% to 100% CONDITIONAL APPROVAL = 70% to 84% NOT APPROVED = less than 70%

Rationale: A well-organized medical record keeping system permits effective and confidential client care and quality review.

1. Format Criteria	Medical Record Reviewer Guidelines—Format
A. An individual medical record is established for each family member.	Providers must be able to readily identify each client treated. A medical record shall be started upon the initial visit for each client. “Family Charts” are not acceptable.
B. Client identification is on each page.	Client identification shall include first and last name, and/or a unique client number established for use at the clinical site.
C. Individual personal biographical information is documented.	Personal biographical information includes: date of birth, current address, home/work phone numbers, and name of parents, if client is a minor. If portions of the personal biographical information are not completed, reviewers should attempt to determine if client has refused to provide information. Do not deduct points if client has not provided all personal information requested by the provider.
D. Emergency “contact” is identified.	The name and phone number of an “emergency contact” person shall be identified for all clients. If the client is a minor, the contact person must be a parent or legal guardian. Emancipated minors and adults may list anyone they so choose. Do not deduct points if client has not provided personal information requested by the provider.
E. Each medical record on site is consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents must be fastened or bound to prevent medical record loss.
G. Client's assigned primary care physician (PCP) is identified.	The assigned PCP is always identified, even when the client selects health care from a nonphysician medical practitioner. Since systems used to identify a client's assigned PCP will differ from site to site, reviewers shall determine specific method used at sites on a case-by-case basis.
H. “Consent for Services” (PM 211 or equivalent) is signed and in the chart.	Each chart will have a signed and dated consent for treatment. If the client is a minor, a legal parent or guardian will have signed the consent for treatment.

Child Health and Disability Prevention (CHDP) Program MEDICAL RECORD REVIEW TOOL

Provider name(s): (1) _____ (2) _____ Contact name: _____
 (3) _____ (4) _____ Reviewer name: _____
 Provider address: _____ Date: _____

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Score
	Provider Initials						
	Member/Client ID Number						
	Age/Gender						
1. Format Criteria	Points						
A. An individual medical record is established for each child/client.	2						
B. Child/client identification is on each page.	1						
C. Individual personal biographical information is documented.	1						
D. Emergency contact is identified.	1						
E. Each medical record on-site is consistently organized.	1						
F. Chart contents are securely fastened.	1						
G. Each child/client has a primary care physician identified.	1						
H. Consent form (PM 211) or equivalent is signed and in the chart.	2						

Rationale: Well-documented medical records facilitate communication and coordination, and promote the efficiency and effectiveness of treatment.

2. Documentation Criteria	Medical Record Reviewer Guidelines—Documentation
A. Allergies are prominently noted.	Allergies and adverse reactions must be listed in a consistent location in the medical record. If client has no allergies/adverse reactions, “No Known Allergies” (NKA) or “No Known Drug Allergies” (NKDA) must be documented.
B. Chronic problems and/or significant conditions are listed.	Chronic conditions include current long-term, on-going problems with slow progress or little progress (e.g., hypertension, depression, diabetes). Documentation can be on a separate problem list or listed in the progress notes.
C. Current continuous medications are listed.	The list of current, on-going medications must include medication name, strength, dosage, route, start/stop dates. Documentation can be on a separate problem list or listed in the progress notes.
D. Informed written consents are present (in record) when appropriate.	Written consents must be signed for operative and invasive procedures, all contraceptive methods, human sterilization, and release of medical information. The parent/legal guardian of a minor may sign a written consent form for medical care.
E. Abnormal reports are reviewed and documented.	Diagnostic (e.g., lab, x-ray) test reports, consultation summaries, in client/discharge records, emergency and urgent care records must have evidence of review by a physician. Evidence of review may be the physician’s initials or signature on the report/record, or a notation in the progress note by physician.
F. Immunization history and record are present.	A history of immunizations received and a copy of the current immunization records should be in the chart.
G. Immunization log meets VFC requirements.	The Immunization Log must have the elements required by the Vaccines for Children (VFC) Program.
H. Errors are corrected according to legal medical documentation standards.	Persons making a documentation error must correct it by drawing a single line through the error, writing “error” above/near the lined-through entry, writing the corrected information, and signing the entry. Erasing and/or use of correction fluid is not acceptable.
I. All entries are signed, co-signed, if applicable, dated and legible.	Signature includes the first initial, last name, and title. Stamped signatures are acceptable, but must be authenticated. Methods used to authenticate signatures in electronic medical records are dependent upon computerized system used on site, and must be individually evaluated by reviewers. Date includes the month/day/year. Nurse Practitioners and Physician’s Assistants must have a cosignature by a physician as required in their respective laws.

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Score
	Provider Initials						
	Member/Client ID Number						
	Age/Gender						
2. Documentation Criteria	Points						
A. Allergies are prominently noted.	2						
B. Chronic problems and/or significant conditions are listed.	1						
C. Current continuous medications are listed.	1						
D. Informed written consents/release of information are present when appropriate.	1						
E. Abnormal reports are reviewed and documented.	2						
F. Immunization history and record are present.	2						
G. Immunization log meets VFC requirements.	2						
H. Errors are corrected according to legal medical documentation standards.	1						
I. All entries are signed, cosigned if applicable, dated and legible.	1						

Rationale: The medical record promotes “seamless” continuity-of-care by communicating the client’s past and current health status and medical treatment, and future health care plans.

3. Coordination and Continuity-of-Care Criteria	Medical Record Reviewer Guidelines—Coordination and Continuity of Care
A. Health History and Initial/Annual Review of Systems are documented.	A comprehensive health history should include the following information for all clients: family/social history, serious accidents, diseases, and surgeries. Pediatric histories should include past prenatal and birth history, growth and development, childhood illnesses. For clients, aged 14 years and above, the past history includes past and current sexual history and tobacco, alcohol, and substance use. An update to the Health History and Review of systems is documented at each periodic visit.
B. Evidence of appropriate exams is documented.	Each visit has a documented diagnosis or impression and based on an age appropriate physical exam, or stated chief complaint or reason for the visit based on client interview. Note: Charts of comprehensive care providers shall have evidence of episodic care.
C. Treatment plans are consistent with diagnoses.	Treatment and/or action plan is documented for each diagnosis, and relates to the stated diagnosis.
D. Client and/or primary caregiver received instructions for follow-up care.	Specific follow-up instructions, along with a definitive time for return visit or other follow-up care is documented. Time period for return visits and/or other follow-up care is definitively stated in number of days, weeks, months, etc., or as needed.
E. Unresolved and/or continuing problems are addressed in subsequent visits.	Documentation shows that unresolved and/or chronic problems are assessed at subsequent visits. All problems need not be addressed at every visit. Reviewer should be able to determine if provider follows up with client about treatment regimens, recommendations, counseling, and referrals.
F. Consultation, referral, and diagnostic test reports are completed.	Medical record contains consultation reports and diagnostic test results for requests ordered. There is documented evidence of review by the examiner.
G. Abnormal test results/diagnostic reports and discussion with client have explicit notation in record.	A physician must review all abnormal and/or “stat” reports with evidence in medical record of follow-up with the client. Record includes notation about client contact or attempted contacts, follow-up treatment and/or instruction provided, and return.
H. Missed appointments and follow-up actions are documented.	Documentation includes incidents of missed appointments and/or examinations. Attempts to contact the client and/or parent/guardian (if minor), and the results of follow-up actions are also documented in the record.

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Score
	Provider Initials						
	Member/Client ID Number						
	Age/Gender						
3. Coordination and Continuity of Care Criteria	Points						
A. Health history and initial/annual review of systems are documented.	2						
B. Evidence of appropriate exams is documented.	2						
C. Treatment plans are consistent with diagnoses.	2						
D. Client and/or primary caregiver received instruction for follow-up care.	2						
E. Unresolved and/or continuing problems are addressed in subsequent visits.	2						
F. Consultation, referral, diagnostic reports, and discussion with client have explicit notation in record.	2						
G. Abnormal test results/diagnostic reports have explicit notation in record.	2						
H. Missed appointments and follow-up contacts/outreach efforts are documented.	2						

4. Pediatric Preventive Criteria	Medical Record Reviewer Guidelines—Pediatric Preventive
A. Initial health assessment and periodic health assessments are completed.	<p>Initial and periodic health assessments are completed according to CHDP periodicity. Initial and periodic health assessments shall have nutrition, dental, health education/anticipatory guidance, developmental and tobacco assessments and guidance. Nutritional assessment requirement includes: (1) anthropometric measurements; (2) laboratory test to screen for anemia (hematocrit or hemoglobin); and (3) breastfeeding/infant formula intake status, food/nutrient intake, and eating habits. Based on problems/conditions identified in the nutritional assessment, reviewers should look for referral of nutritionally at-risk children under five years of age to the Women, Infants and Children (WIC) Supplemental Nutrition Program, or for medical nutrition therapy and/or other in-depth nutritional assessment as appropriate. Dental assessment includes an inspection of the mouth, teeth, and gums at every health assessment visit. Children are referred to a dentist at any age if a dental problem is detected or suspected. Health Education/Anticipatory Guidance is provided at each health assessment visit. This includes providing or referring to counseling, and providing appropriate, specifically related educational materials. Identified problems and interventions (nutrition counseling, parenting classes, smoking cessation programs, etc.) are addressed in the progress notes.</p>
B. Age-appropriate history and physical exams are according to CHDP periodicity.	<p>CHDP Program pediatric preventive physical examinations are completed at each health assessment visit which include: (1) review of systems and interval histories as appropriate; (2) anthropometric measurements of weight and length/height, and head circumference of infants up to age 24 months; (3) physical examination/body inspection, including screening for sexually transmitted diseases (STD) of sexually active adolescents. Assessments are appropriately recorded on Confidential Screening/Billing Report (PM 160) forms, with identified problems documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate.</p>
C. Vision screening (Snellen test or equivalent) is completed.	<p>Vision screening is completed with results according to CHDP periodicity. Screening for visual problems should occur at each health assessment visit. Vision screening for infants and children from birth to three years of age consists of a red reflex examination, corneal penlight evaluation, and an external eye inspection. The CHDP assessment includes visual acuity screening beginning at age three years. Picture recognition posters or Snellen “tumbling E” charts are recommended for children from three to six years of age, and Snellen letter charts for children over age six years. The method used for visual screening varies depending on the age, maturity, and language development level of the child. CHDP recommends that any child unable to be tested after two attempts or in whom an abnormality is detected be referred for an initial eye evaluation by an ophthalmologist experienced in the care of children. Referral to an optometrist or ophthalmologist is provided as appropriate.</p>

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Score
	Provider Initials						
	Member/Client ID Number						
	Age/Gender						
4. Pediatric Preventive Criteria	Points						
A. Initial and Periodic Health Assessments are completed.							
1. Nutritional assessment.	2						
2. Dental assessment.	2						
3. Health education/anticipatory guidance.	2						
4. Developmental assessment.	2						
5. Tobacco assessment.	2						
B. Age-appropriate history and physical exams are current according to CHDP periodicity.	2						
C. Vision screening (Snellen test or equivalent) is completed.	2						

4. Pediatric Preventive Criteria (con't)	Medical Record Reviewer Guidelines—Pediatric Preventive
D. Hearing screening is completed.	The American Academy of Pediatrics (AAP) recommends initial newborn hearing screening prior to discharge from the delivery hospital or by approximately one month of age. The CHDP assessment for hearing problems includes nonaudiometric screening for infants and children from two months through two years of age. Nonaudiometric screening may include an assessment of speech and language development, a family and medical history, parental concerns, physical examination, and use of measured noisemakers or sound generators. Audiometric screening is done on children and young adults from age 3–20 years at each health assessment visit. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on two screenings separated by an interval of at least two weeks and no later than six weeks after the initial screening are referred to a specialist. Follow-up care or referral to specialist is provided as appropriate.
E. CHDP lab work is present.	Each child has a hemoglobin (Hgb) or hematocrit (Hct), urine for dipstick or analysis, and other lab as appropriate for age and according to the CHDP periodicity schedule. Urine is tested at each health assessment visit starting at age four to five years.
F. Lead testing is completed according to current CHDP standards.	Follow the current lead protocol for CHDP. Follow-up care or referral to specialist is provided as appropriate.
G. TB risk assessment and/or tuberculin skin test is completed.	The Mantoux skin test is administered at the health assessment visits during age 4–5 years and age 11–16 years. However, all children are screened for risk of exposure to tuberculosis (TB) at each health assessment visit. The Mantoux skin test is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux skin test is not administered if the child has had a previously documented positive Mantoux skin test. The skin test is read by trained personnel 48–72 hours after administration, and is recorded in millimeters (mm) of induration. See the Health Assessment Guidelines for induration definition. If the child fails to return for the scheduled reading: (1) a positive reaction may still be measurable up to one week after testing, or (2) the skin test for a negative Mantoux is repeated. Children with positive reactions receive follow-up medical evaluation, chest x-ray, and other needed diagnostic laboratory studies, or referral to specialist as appropriate.
H. Childhood immunizations are up-to-date.	There is a consolidated immunization record present. Immunization status is assessed at each health assessment visit and during each encounter. All needed vaccines are administered according to guidelines established by the Public Health Service Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent. For each vaccine, the manufacturer and lot number is recorded in the medical record.

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Score
	Provider Initials						
	Member/Client ID Number						
	Age/Gender						
4. Pediatric Preventive Criteria (continued)	Points						
D. Hearing screening (nonaudiometric and/or audiometric test) is completed.	2						
E. CHDP lab work is present.	2						
1. Hgb/Hct	2						
2. Urine/dipstick	2						
3. Other	2						
F. Lead testing is completed according to current CHDP standards.	2						
G. TB risk assessment and/or tuberculin skin test is completed.	2						
H. Childhood Immunizations (IZs) are up-to-date:							
1. Immunization summary page is present and includes consolidation of IZs from other sources.	2						
2. IZs were given when due?	2						
3. VFC documentation guidelines for administration of IZs are followed.	2						

4. Pediatric Preventive Criteria (con't)	Medical Record Reviewer Guidelines—Pediatric Preventive
I. Other testing is completed as appropriate for age.	Pap smears, chlamydia testing, or other sexually transmitted disease (STD) testing is performed as appropriate for age.
J. If Health Assessment Only examiner, child/client is referred to a medical and dental home. Or If Comprehensive Health Provider, referred client to a dental home.	Health Assessment Only providers have documented a referral to both a medical and dental provider. Beginning at age three years, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected. If a Comprehensive Health Care Examiner, the examiner has made an annual referral to a dentist regardless of whether a dental problem is detected or suspected.
K. Appropriate growth measurements are taken and plotted at each visit.	When appropriate for age, each child/client under the age of two has a head circumference taken and plotted on a growth chart. Each child/client over the age of two has a Body Mass Index (BMI) determined and plotted. Each child/client has a length/height and weight taken and plotted at each visit.
L. Blood pressure is measured at each visit as appropriate for age.	Blood pressure (BP) is measured and recorded at each visit starting at three years of age. If hypertension (BP \geq 95 th percentile for age and sex) is suspected, the child's position, limb, and cuff size are documented in the medical record. The BP measurement is repeated if \geq the 90 th percentile for age and sex.
M. Reporting health assessment results on statewide report form (Confidential Screening/Billing Report PM 160) concurs with documentation in the client's medical record.	The findings of the health assessment are recorded in the client's medical record and are reported on the statewide report form known as the Confidential Screening/Billing Report (PM 160). The findings recorded and reported are the same for the date of service.

Criteria met: Give full points. Criteria not met: 0 points Criteria not applicable: N/A (Give full points.)		Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Medical Record Number	Score
	Provider Initials						
	Member/Client ID Number						
	Age/Gender						
4. Pediatric Preventive Criteria (continued)	Points						
I. Other testing completed as appropriate for age, such as Pap, STD testing.	2						
J. 1. If Health Assessment Only Provider, referred client to a medical and dental home. Or 2. If Comprehensive Health Provider, referred client to a dental home.	2						
K. Appropriate growth measurements are taken and plotted at each visit.							
1. Head Circumference	2						
2. Body Mass Index (BMI)	2						
3. Weight	2						
4. Length/Height	2						
L. Blood pressure is measured at each visit as appropriate for age.	2						
M. Reporting of health assessment results on Confidential Screening/Billing Report (PM 160) concurs with documentation in the child/client's medical record.	2						